Gender-Affirming Care is Primary Care

Transition-related Care in **Newfoundland & Labrador**



NL Gender-Affirming Care Toolkit

TRANS SUPPORT NL

A Message to Providers

Trans and gender-diverse people in Newfoundland & Labrador face real barriers to accessing hormone therapy and transition-related surgeries. The biggest reason: too few primary care physicians and nurse practitioners offer this support.[1]

But the foundation is already there.

You likely already prescribe and monitor hormones, assess surgical eligibility, and manage ongoing care. The jump to transition-related care is smaller than you might think.



This guide gives you a plain-language, patient-centred introduction to gender-affirming care to help you get started — and getting started is the biggest step. For patients who otherwise can't access this care, your willingness to learn will be life-changing.

This resource draws on community knowledge from right here in Newfoundland & Labrador, so it speaks to the real needs and hopes of patients in this province.

It's meant to sit alongside the clinical resources that already exist, not replace them — you'll find the Rainbow Health Ontario (RHO) Quick Reference Guide and the NL Health and Community Services Transition-Related Surgery package in the appendix.

We're glad you're here. Trans and gender-diverse people in this province need more providers who are ready and willing to offer this care. Read on, and take the first step toward becoming one of them.

Trans Support NL Team

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Land Acknowledgement

As we live, work, and provide care in Newfoundland and Labrador, we acknowledge that this land is the traditional and ancestral homeland of diverse Indigenous Peoples who have lived here for thousands of years. We recognize that acknowledging the land also means actively working against the harms of colonialism. True reconciliation involves listening to, learning from, and standing alongside Indigenous communities, especially Indigenous Two-Spirit and trans leaders, who continue to guide movements for justice.

Colonialism, Healthcare, and Gender

Colonization has deeply shaped the healthcare system and disrupted many Indigenous cultures' traditional understandings of gender. Long before colonization, gender diversity was recognized and respected across many Nations — held with distinct names, roles, and places within community.

Today, Indigenous Two-Spirit, trans, non-binary, and gender-diverse people often face intersecting barriers to care, including systemic racism, medical discrimination, and a lack of culturally safe, gender-affirming services. These harms are compounded by broader social determinants of health such as land displacement, intergenerational trauma, and ongoing colonial violence.

Providing gender-affirming healthcare requires an anti-colonial approach that acknowledges Indigenous sovereignty and supports traditional, holistic healing practices. This includes engaging with Indigenous-led organizations, integrating Two-Spirit teachings where invited, and offering trauma-informed care. Providers must recognize that gender-affirming care is not separate from, but deeply connected to, the broader work of Indigenous rights and decolonization.

Purpose

Gender-Affirming Care is Primary Care: Transition-related Care in Newfoundland & Labrador part of Trans Support NL's **Gender-Affirming Care Toolkit.**

Written primarily for primary care physicians and nurse practitioners, it offers NL-specific introductory information on hormone therapy, surgical readiness assessments, MCP coverage, and provincial care pathways — alongside nationally recognized clinical guidelines.

The goal: more primary care providers equipped to offer gender-affirming care, and better access to it for trans and gender-diverse people across Newfoundland & Labrador.

NL Gender-Affirming Care Toolkit Site

tsnl.org/
nl-gender-affirming-care-toolkit

Acknowledgements

This work was made possible thanks to Trans Support NL staff Quinn Jesso, Sydney Knapman, Morgen Mills, Shaye Murray, and Logan St. Croix and our Two Spirit, trans, nonbinary, intersex, and gender-diverse community members. We also thank Kate McHardy for design and illustration, Community Advisory Board members including Heather Loader, Noah Pevie (MARSS Lab, Western University), and Lee Turner, as well as medical reviewers including Dr. Natalie Bridger (MD, FRCPC, DTM&H, Associate Professor of Pediatrics, Memorial University), Dr. Christopher Ryan (MD, FRCPC), Dr. Aaron Grant (MD, FRCSC), and Dr. Kerry-Lynn Williams (Labrador Health Centre, Memorial University). We are thankful to Rainbow Health Ontario and Dr. Amy Bourns for permission to include the RHO Guidelines for Gender-Affirming Primary Care with trans and non-binary patients. Trans Support NL is grateful for the generous funding support from Women and Gender Equality Canada that made this project possible.

Women and Gender Equality Canada
Femmes et Égalité des genres Canada
Canada

Gender-Affirming Medical Care in NL

Accessing gender-affirming care (GAC) in Newfoundland & Labrador remains one of the most significant challenges for trans, non-binary, and gender-diverse people.

This care can be life-saving—reducing depression, anxiety, and suicide risk. Yet many patients face long waits, potentially avoidable referrals, and discouraging or discriminatory encounters that can delay or prevent care[2] .

Strengthening primary care's role in gender-affirming treatment is essential to address these gaps and create a system that is sustainable, affirming, and life-saving.





Gender-Affirming Primary Care

Newfoundland & Labrador has a significant gender-diverse population[3]. A 2025 TSNL provincial patient survey found strong demand for better access to gender-affirming care and better provider training[1].

In clinical terms, most gender-affirming care is more familiar to primary care providers than its reputation might suggest. It involves medications, investigations, and monitoring that are commonplace for all primary care providers. Many providers even practice forms of gender-related care for cisgender patients already: treating hair loss, erectile dysfunction, and perimenopausal or postmenopausal symptoms.

Proportion of Gender-Diverse Canadians by Age[3]

1-in-300 (all ages 15+)
1-in-200 (born 1981-1996)
1-in-100 (born 1997-2012)

Gender-diverse patients are affected by the same primary care shortages as others in the province. But even those who have a primary care provider are often unable to receive gender-affirming care within that relationship[4]. Instead, they may encounter barriers to treatment such as unnecessary assessments and referrals, or discrimination based on their gender identity. In TSNL's 2025 survey, 84% of respondents reported being referred to another provider for some or all of their GAC[1].

Gender-affirming care is already included in primary care.

Providers new to gender-affirming care can benefit from a wealth of clear guidelines, expert consultations, and a grateful patient population who values curiosity and a willingness to learn.

Your Role in Gender-Affirming Care

Managing gender-affirming care can be a highly rewarding experience.

As a trusted advocate and guide during a life-affirming process, your support will be a major factor in a patient's experience of transition.

While some primary care providers focus solely on gender-related care, all are qualified to initiate it. Compared to its lifelong impact, the time spent learning about gender-affirming care will be a worthwhile investment.

Your role is to:

Understand the patient's needs, goals, and lived experience.
Validate the patient's identity and your role in clinically supporting them.
Facilitate informed, timely care through management and navigation.

Your role is not to:

Adjudicate a patient's gender identity.
Dismiss a patient's distress, concerns, or desire to seek care.
Persuade against timely transition because of potential hardships.



Initiating basic gender-affirming care like hormone therapy **does not require a letter** from a counsellor or psychiatrist.

Barriers to Accessing GAC

TSNL's Patient Outreach Survey[1] identified several common barriers to accessing GAC:

• Long wait times for appointments	**2-in-3 people**
• Lack of knowledgeable providers	**1-in-2 people**
• Cost or lack of insurance	**2-in-5 people**
• Unclear or complicated process	**2-in-5 people**
• Need to travel long distances	**1-in-3 people**
• Mental health challenges that made it difficult to seek care	**2-in-5 people**



The Risks of Referred Care



Most patients approach their provider for gender-affirming care after years of privately grappling with their gender identity[5]. In that moment, providers face a consequential decision: provide GAC within their own practice, or refer to another provider.

For providers unfamiliar with GAC, referred care may seem like the most responsible option: deferring to a more experienced practitioner is often motivated by care, not reluctance. For most patients, however, providing care directly reduces harm, and out-referrals are not usually indicated.

Delayed Care

For patients in this province, referred care inevitably results in delayed care. While year-long waits for specialists have become the norm, gender-affirming hormone therapy (GAHT) falls within the scope of family medicine.

> Those planning but unable to start GAHT are twice as likely to attempt or seriously consider **suicide** as those already in care[6].

For many patients, such wait times can intensify distress during the period between seeking care and finally receiving it[7]. When care is integrated, even by a provider new to GAC, safe and effective treatment can begin much sooner.

Providers don't need to work in isolation. Consultation and targeted referrals are important tools. But in most cases, GAC is best supported within an ongoing primary care relationship[4].

Satisfaction Rates

Gender-affirming Hormone Therapy

98% satisfaction rate
(n = 43,334)

80% satisfaction rate
8% increasing HRT dose
(n = 696)

95% satisfaction rate
(n = 83)

Transition Related Surgery

97% satisfaction rate
(n = 18,686)

99% satisfaction rate
(n = 7928)

100% satisfaction rate
(n = 22)

Managing Concerns of Regret

Some gender-diverse individuals experience gender dysphoria, which is conceptualized as a clinically significant level of distress felt when their gender identity does not align with their sex assigned at birth (SSAB). Depending on the source of their distress, patients may benefit from a range of supports, including social or psychological support and, where appropriate, medical interventions such as gender-affirming hormone therapy (GAHT) or transition-related surgeries (TRS).

While some medical interventions have lasting or irreversible effects, these must be weighed against the potential harms of delaying or withholding care. Treatment decisions should reflect the patient's goals, medical context, and informed consent. Concerns about treatment regret or future decisions to discontinue or reverse aspects of gender-affirming medical care (known as detransition) should inform individualized discussions but should not, in themselves, be grounds for withholding care.

Satisfaction with Gender-affirming Medical Care

Research consistently demonstrates high satisfaction among people accessing gender-affirming medical care. For example, the National Center for Transgender Equality surveyed tens of thousands of individuals who accessed gender-affirming hormone therapy or transition-related surgery found overwhelmingly positive satisfaction rates[#].

Gender-affirming Hormone Therapy

98% satisfaction rate (n = 43,334)[#]

Transition Related Surgery

97% satisfaction rate (n = 18,686)[#]

Duty of Care Standards

Primary care providers have a duty to provide gender-affirming care. This toolkit assists and encourages providers to meet that duty.

Scope of Practice

The College of Family Physicians of Canada explicitly supports the provision of high-quality, evidence-based gender-affirming care by family doctors[8]. However, some physicians and other primary care providers feel that gender-affirming care is outside their scope of practice.

The standards of the College of Physicians and Surgeons of NL also state that a patient cannot be refused on the grounds that their care is complex or time-consuming, or on the basis of their gender identity[9]. As in other areas of practice, providers whose patients require gender-affirming care can seek out professional development to meet their specific needs.

When Referral Is Necessary

Family physicians with extensive gender-affirming care experience are an invaluable resource, particularly when aspects of a case are atypical or complex. In many cases, it is sufficient to consult these experienced providers, rather than referring patients to their care. Even when a referral is deemed appropriate, care can be made more accessible by consulting with the receiving provider to clarify which longitudinal duties can be carried out in the primary care setting.

Patients on lengthy waitlists for gender-affirming care require routine and vigilant monitoring by their existing provider. The referring provider is also the most responsible for care if changes in patient status indicate reassessment or response.

Children and GAC

Social transition and affirming spaces can make a big difference for gender-diverse people of any age[10]. While this resource focuses on care for post-pubescent patients, youth have the right to access developmentally appropriate care. Primary care for trans youth may involve specific interventions and considerations, and providers will benefit from consulting with colleagues experienced in working with youth.

Puberty blockers act like a "pause button" on puberty, stopping unwanted body changes like voice deepening or breast growth which can be very distressing. This gives young people more time to think about their gender identity without the pressure of their bodies changing in ways they don't want.

Gender-Affirming Hormone Therapy may be indicated for older youth to support physical changes that align with their gender identity. This is typically considered when the young person demonstrates sustained gender dysphoria or gender-incongruent identity, and is able to participate in informed consent discussions appropriate to their developmental level.

Surgeries: While most gender-affirming surgeries are not available to minors in Newfoundland & Labrador, providers can play a role in discussing and preparing youth for these options in the future.





Clinical Conversations

No matter how long you've known a patient, starting a conversation about gender-affirming care can feel overwhelming—for both the patient and the provider. But it doesn't have to be. Providers are well-equipped to have difficult conversations.

This chapter shares key ideas and tools to help you approach these conversations with confidence, compassion, and clarity.

Discussing Gender-affirming Care

Each patient's gender-related concerns and goals will be unique. Some patients will be just starting to explore gender and feel uncertain, while others will have a strong sense of who they are and what they need. These conversations may be a part of a gender-focused appointment or may come up during an unrelated visit.

What to Do in That First Conversation

No matter what the patient's situation, your job is the same:

Avoid assumptions: Don't assume a person's pronouns, gender identity, or goals for gender-affirming care. Ask respectfully and let the patient guide the conversation. Make sure this information is documented in a way that can be reliably referenced and used by you and your staff.

Show you care: Create a supportive first impression by thanking the patient for sharing and reinforcing that they deserve respectful, affirming care.

Find out why they're telling you: Are they looking for treatment? Feeling distressed or at risk? Or do they just want to be correctly addressed?

Be upfront: Tell them about your overall experience with GAC, while also signaling your commitment to providing timely and effective care.

Make a plan: Before they leave, schedule a follow-up appointment. Gather information to help you both prepare for the next visit.



The Planning Phase

The planning phase helps patient and provider prepare for gender-affirming care by understanding the clinical goals and treatments and, just as importantly, by understanding each other. It may happen over one or several visits.

Informed Consent & The Planning Phase

Historically, providers have acted as gatekeepers of gender-affirming care, withholding treatment from the patient until medical experts deemed them eligible to receive it. As gender-diversity has become depathologized, informed consent has become a preferred model of care[11]. It lowers the barriers by respecting a patient's sense of self and ability to make an informed choice, and including their experience and judgement as valid sources for clinical decision-making.

The threshold for initiating care in an informed consent model[11]:

- the patient demonstrates capacity to consent
- the patient and the provider understand potential risks, outcomes, and options in the context of the patient's goals.





Talking About the Planning Phase

Patients may arrive with different expectations about whether they will be able to receive gender-affirming care. Openly discussing the purpose of this phase can reduce uncertainty and establish a more honest clinical relationship.

Explain its purpose: The goal is to build a strong foundation for the provider and patient to understand, explore, and plan effective care: not to evaluate whether the patient's identity is valid or worthy of treatment.

Acknowledge individual pacing: Different patients and providers need different amounts of planning time depending on goals, circumstances, and experience. Anticipate and address concerns about gatekeeping.

Emphasize collaboration: Frame the planning phase as the start of a partnership guided by informed consent. Together, you are clarifying goals, reviewing options, and discussing risks and outcomes so care can move forward with clarity and confidence.



Goals of the Planning Phase

1. Understanding Their Lived Experience

Give the patient time to share their story to help guide their care.

Gendered experiences: How have their experiences with gender changed over time? How do they describe key developments and insights of their journey? How do they express their gender—in private and in public?

Their medical context: Explore medical, psychological, social, and family histories; perform relevant clinical examinations. Ask about any existing self-medicating, assuring them that it is not a barrier to care.

Immediate risks: Ask about stressors, mental health concerns, and experiences of discrimination, violence, self-harm, and suicidal thoughts. Prioritize safety and stabilization in parallel with treatment planning.

Causes of distress and joy: Identify aspects of gender that are sources of dysphoria or euphoria.

Social and cultural context: Ask about family dynamics, cultural background, religious beliefs, and community connections that may shape their experiences now and during treatment.



2. Exploring Desired Outcomes

Gender-affirming care involves setting clear goals with your patient.

Short-term outcomes might include social transition steps, mental health support, desired medical treatments, fertility planning (which must be addressed before starting hormone therapy if fertility preservation is desired), and clinical outcomes.

Long-term outcomes help patients think about their broader vision, even if details stay flexible. This could include surgical options, social transition, or other factors related to or impacted by gender.

3. Exploring Challenges & Identifying Supports

Review the patient's support systems and potential challenges.

Social environment: Discuss family relationships, friendships, community, work, or school connections that may support or hinder their care.

Financial barriers: GAC can involve a range of costs, including travel costs; some may be funded from MCP or private insurance, while others may be out-of-pocket expenses. Discuss your patient's goals in light of their financial situation.

Mental health needs: Transitioning is a life-changing event. Many patients benefit from mental health support, which should be integrated into care if indicated by individual circumstances rather than as a prerequisite for accessing gender-affirming treatment[12].



4. Patient Education

Patients should be informed about available treatment options, costs, timelines, outcomes, side effects, and monitoring.

Reviewing treatment options: Patients need detailed information about available interventions, from social transition to hormones to surgery.

Setting realistic expectations: Have honest conversations about possible timelines, outcomes, and limitations of treatments. Discuss the physical, social, and emotional aspects of transition.

Discussing risks and benefits: Discuss benefits, risks, costs, and other considerations to support informed decision making surrounding treatment options

Connecting to resources: Support beyond the clinic may include peer groups, service navigation, counselling, and paramedical options.



5. Provider Education

Prepare for each visit by learning about care relevant to your patient. During each visit, seek information to guide that learning. This may include:

Hormone therapies: Learn about different hormone options, titration schedules, monitoring protocols, side effects, and contraindications—directed by the individual context of the patient.

Surgical options: Learn about available options, necessary prerequisites, typical timelines, and pre- and post-operative care.

Non-medical/paramedical options: Voice training, hair removal, and 'gender gear' (e.g., binders to flatten chests or packers to create visible genital bulges) can help gender expression.

Intersectionality: Consider what factors may shape and impact the patient's identity and expression. Explore how race, class, religion, disability, and other factors intersect with your patient's gender.

Local resources: Familiarize yourself with specialized providers, support organizations, and community services to support your patient.

Consultations: Consider consulting experienced health care providers. Complex situations may call for collaboration between primary care, mental health, endocrinology, and other specialties.

Continuing education: Explore additional resources and training opportunities to improve your long-term competency with GAC.



From Planning to Treatment

One of the main goals of the planning phase is to prepare the patient and provider to begin treatment.

Gender-affirming care is like any other care, in that it's most effective when there is a shared understanding of the patient's goals, circumstances, and concerns, as well as the available options.

Gender-affirming care is unlike many other areas of care in that the patient often anticipates new changes to their body and sense of self. Some patients may also face social stigma related to their decision to seek gender-affirming care, and many face more general barriers to acceptance. Under these circumstances, patients may particularly benefit from clarity of alignment and readiness in the planning phase.

Provider readiness

- Understands available treatments, side effects, and indications
- Has completed or ordered baseline investigations
- Knows the patient's goals, preferences, and health and social context

Patient readiness

- Understands treatment options, including risks, benefits, and costs
- Has realistic expectations of timeline and outcome variability
- Feels confident in the partnership and their role in ongoing care



Hormone Therapy

Starting **gender-affirming hormone therapy (GAHT)** can be an exciting and formative step in a patient's gender journey. Beyond its physical, mental, and social outcomes, it can also foster a sense of personal and medical autonomy.

This chapter complements Rainbow Health Ontario's (RHO) **Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients**[11], which covers therapies, doses, labs, and adjuncts. We encourage primary care providers to familiarize themselves with the full RHO guidelines.

Here, we focus on patient experience and on the patient-provider relationship, areas that are less explored in existing guidelines for GAHT.

More Familiar Than You Think

If you treat perimenopause, erectile dysfunction, or hair loss, you already practice **gender-affirming hormone therapy (GAHT).** Transition-related care follows the same principles.



GAHT resembles other endocrine therapies: monitoring levels, titrating doses based on investigation and clinical response, maintaining target ranges, and monitoring for adverse effects. They also include familiar medications, like testosterone, estradiol, and spironolactone.

Gender-affirming care is recognized as part of comprehensive primary care practice. Patients seek gender-affirming care at a similar rate to many other forms of care. **1-in-300 people identify as transgender or non-binary**[3]: a prevalence comparable to those with Crohn's Disease or Type 1 Diabetes[13].

Building competency in gender-affirming care involves applying clinical principles that are familiar to all primary care providers: patient-centred care, informed consent, and careful monitoring.



Guides & Standards of Care

While gender-affirming hormone therapy is a deeply individualized domain of medicine, well-established guides and standards of care exist to serve as a knowledge base for your practice.

The most referenced guide is the **Standards of Care for the Health of Transgender and Gender Diverse People**, which is published by World Professional Association for Transgender Health (WPATH) and represents an international consensus on gender-affirming care, including GAHT.

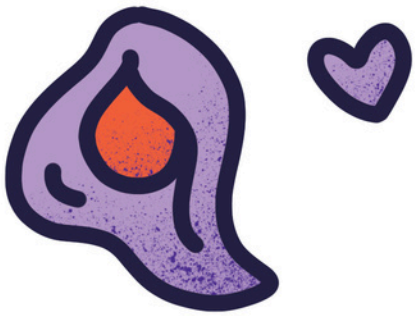
In Canada, the two most substantial guides are **Trans Care BC's Primary Care Toolkit**[14] and **Rainbow Health Ontario's guidelines**[11].

A quick reference guide from Rainbow Health Ontario is included in the back of this toolkit[11].



Estrogen-based Therapies

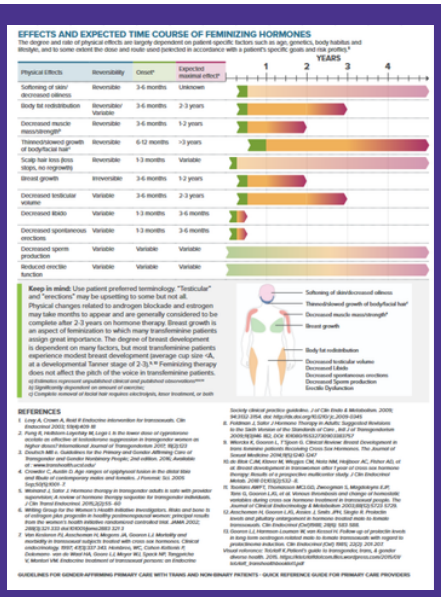




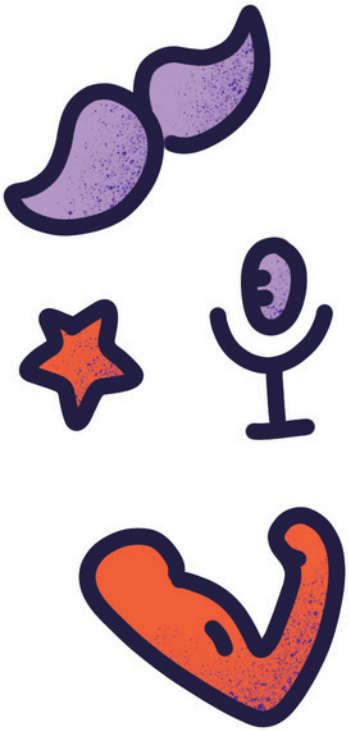
Estrogen-based therapies are a crucial component of gender-affirming care for **transfeminine** and some **non-binary** patients who seek to align their physical appearance with their gender identity. The primary goal is the development of female secondary sex characteristics and the suppression of male secondary sex characteristics.

Treatment typically involves the use of estrogen in combination with anti-androgens. Estrogens directly act on estrogen receptors to initiate feminizing effects. Anti-androgens are necessary alongside estrogen to effectively reach female physiologic hormone ranges and to minimize masculine physical traits. In some instances other medications – like progesterone and 5-ARIs (such as finasteride) – may also be considered as adjuncts.

Rainbow Health Ontario's guidelines—found in the back of this toolkit—provide clear information on the starting therapies and doses, clinical and laboratory investigations, and anticipated outcomes and timelines of feminizing therapies[11].


EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES

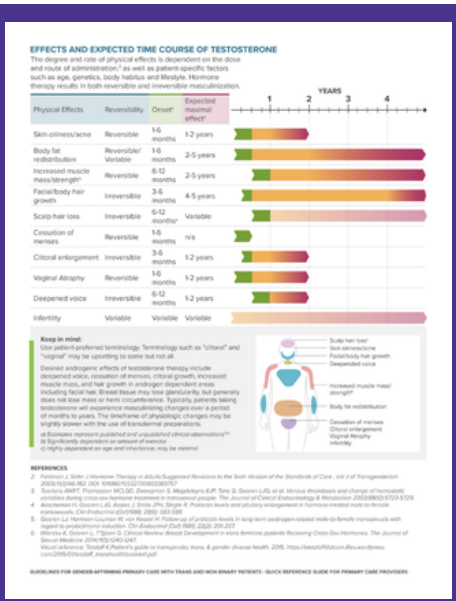
Testosterone-based Therapies



Testosterone-based therapies are a crucial component of gender-affirming care for **transmasculine** and some non-binary patients who seek to align their physiology with their gender identity. The primary goal is the development of male secondary sex characteristics and the suppression of female secondary sex characteristics.

Treatment involves the use of testosterone, which is the cornerstone of therapy used to induce masculinizing effects. Testosterone-based therapy has a dominant effect on the endocrine system and therefore does not typically require sex-hormone blockers.

Rainbow Health Ontario's guidelines—found in the back of this toolkit—provide clear information on the starting therapies and doses, clinical and laboratory investigations, and anticipated outcomes and timelines of testosterone therapies[11].


EFFECTS AND EXPECTED TIME COURSE OF TESTOSTERONE

The degree and rate of physical effects is dependent on the dose and route of administration,[1] as well as patient-specific factors such as age, genetics, body habitus and lifestyle. Hormone therapy results in both reversible and irreversible masculinization.

Physical Effects	Reversibility	Onset*	Expected maximal effect*
Skin oiliness/acne	Reversible	1-6 months	1-2 years
Body fat redistribution	Reversible/ Variable	1-6 months	2-5 years
Increased muscle mass/strength**	Reversible	6-12 months	2-5 years
Facial/body hair growth	Irreversible	3-6 months	4-5 years
Scalp hair loss	Irreversible	6-12 months†	Variable
Cessation of menses	Reversible	1-6 months	n/a
Clitoral enlargement	Irreversible	3-6 months	1-2 years
Vaginal Atrophy	Reversible	1-6 months	1-2 years
Deepened voice	Irreversible	6-12 months	1-2 years
Infertility	Variable	Variable	Variable

YEARS 1 2 3 4

Keep in mind:

Use patient-preferred terminology. Terminology such as "clitoral" and "vaginal" may be upsetting to some but not all.

Desired androgenic effects of testosterone therapy include deepened voice, cessation of menses, clitoral growth, increased muscle mass, and hair growth in androgen dependent areas including facial hair. Breast tissue may lose glandularity, but generally does not lose mass or hemi circumference. Typically, patients taking testosterone will experience masculinizing changes over a period of months to years. The timeframe of physiologic changes may be slightly slower with the use of transdermal preparations.

a) Estimates represent published and unpublished clinical observations[1,4]
b) Significantly dependent on amount of exercise
c) Highly dependent on age and inheritance; may be minimal

Scalp hair loss*
Skin oiliness/acne
Facial/body hair growth
Deepened voice
Increased muscle mass/ strength**
Body fat redistribution
Cessation of menses
Clitoral enlargement
Vaginal Atrophy
Infertility

REFERENCES

GUIDELINES FOR GENDER-AFFIRMING PRIMARY CARE WITH TRANS AND NON-BINARY PATIENTS - QUICK REFERENCE GUIDE FOR PRIMARY CARE PROVIDERS

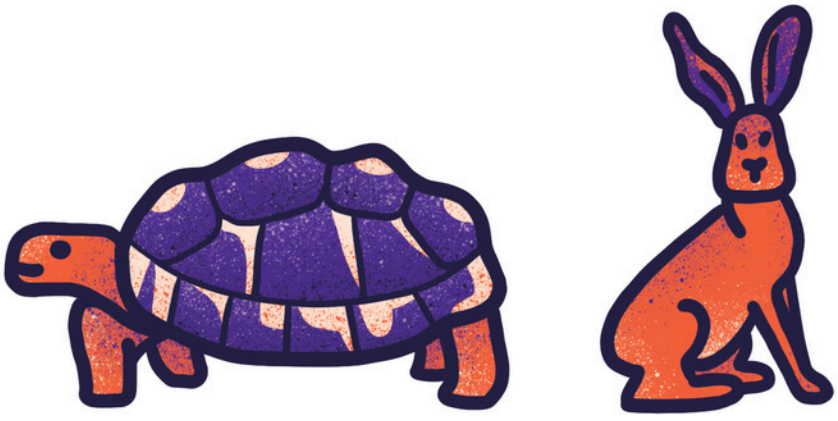
Dosing, Timing, and Patient Goals

When discussing dosing and timing, start with what the patient hopes to achieve. Hormone therapy isn't only about reaching target levels—it's about shaping changes in ways that best serve the patient's care.

Guidelines as a starting point: Standards like the WPATH Standards of Care[15, 16] offer a general consensus rather than absolute minimum and maximum effective dosing ranges. Starting doses can reflect the patient's goals, lived experience, health status, and comfort with risk.

Pacing and priorities: Some people want a slower, more gradual regimen —giving themselves time to adjust to physical and emotional changes. Others may wish to move more quickly toward outcomes that feel urgent or deeply affirming, like voice changes or menstrual suppression. Some may fall somewhere in between. Each approach carries its own risk profile to be weighed openly with the patient.

Collaborative decisions: Dosing and timing aren't one-time decisions—they unfold through ongoing conversations, experiences, research, and outcomes. Combining your clinical insight with the goals and experiences of the patient can lead to a plan that is safe, achievable, and impactful.



Clinical Expertise in Patient-led Care



A patient's bodily autonomy is central to medical transition—but so is your clinical perspective. Sharing your clinical reasoning, evidence, and patient-centred discussion strengthens trust, improves safety, and leads to better outcomes.

The role of established protocols: For providers offering GAHT, established protocols provide a structured starting point for planning care and treatment decisions. These protocols are based on current evidence and clinical guidelines and can support consistent approaches to care. As many GAHT outcomes develop over months to years, ongoing assessment and adjustment of care plans may be needed. Communicating this early can help patients set expectations that care plans can evolve over time in response to the patient's goals and needs.



Applying your clinical approach: Providers may differ in how they assess risk, manage uncertainty, and apply clinical guidelines. Some may follow established protocols more closely, while others may individualize care earlier based on the patient's circumstances and goals. Discussing these considerations can help patients understand how treatment decisions are being made.



Supporting autonomy with clinical judgment: Patient-led care is most effective when supported by honest clinical guidance. Your role is to discuss evidence-informed recommendations, review potential benefits and risks, and work collaboratively with patients to develop an informed and individualized care plan.

Discussing Adherence

Once treatment begins, communicate how consistent adherence becomes essential for both therapeutic success and meaningful monitoring.

Day-to-day wellbeing can be affected by inconsistent hormone levels caused by adherence issues. Patients may experience mood swings, energy fluctuations, and other symptoms tied to sex hormones.

Monitoring becomes less reliable when adherence is inconsistent, impairing your ability to interpret results and make dosing decisions.

Post-gonadectomy patients lack internal hormone production and are particularly vulnerable if adherence is inconsistent. Missing doses regularly can cause significant deficiency symptoms that impact overall wellbeing.



Addressing Adherence Challenges

Discussing common adherence challenges early and proactively helps the patient to develop strategies for consistent medication use.

Financial constraints: Cost can limit access and lead to rationing. Explore public coverage, generics, or alternative modalities.

Executive functioning challenges: Even motivated patients may struggle with routines. Suggest reminders, pill organizers, apps, blister packs, setting alarms, pharmacy delivery, or tying medications to daily habits.

Stigma concerns: Worry about being "outed" may deter treatment[17]. Consider strategies to support patient concerns, such as out-of-neighbourhood prescribers and tools like binders to protect their privacy and safety if necessary.

Modality intolerances: Needle phobia, injection technique, trouble swallowing, or skin reactions may affect adherence. For patients who encounter difficulties with injections, consider sublinguals, gels, switching methods or sites, or options for a support person to deliver the injections.

Side-effect intolerances: Monitor side effects early and without prompting. Reassure patients that most side effects can be managed without discontinuation. Explore timing, dose, and modality alternatives.

When Doses Are Missed

Provide proactive, practical guidance about what to do when a dose is missed. Emphasize importance of long-term adherence while normalizing that occasional missed doses may occur.



Discussing Bloodwork Collection

Effective monitoring involves more than ordering tests—it means preparing patients for the challenges and responsibilities involved.



Explaining the role of bloodwork: Help patients understand that bloodwork monitors levels to screen for adverse effects and guide dose adjustments. When patients see how results directly inform their care, they're more likely to engage fully with monitoring procedures[18]. Note that lab reference ranges may reflect their MCP gender marker, not their sex assigned at birth.

Reviewing the logistics: Develop a plan with patients that ensures accuracy, convenience, and privacy. Discuss how they'd like to receive requisitions—mailed to the home, faxed to the collection site, or picked up at the clinic. Review timelines for collection, results turnaround, and follow-up. For those with medical trauma or needle anxiety, explore supports like bringing a friend or scheduling recovery time.



Addressing "outing" concerns: Blood collection may be associated with anxiety, prior medical trauma, or concerns regarding misgendering and privacy. It can be even harder if you're worried about being misgendered in a room full of people. Tell patients when legal names and gender markers must appear on requisitions. Encourage patients to share anticipated challenges, such as misgendering, so you can plan together.

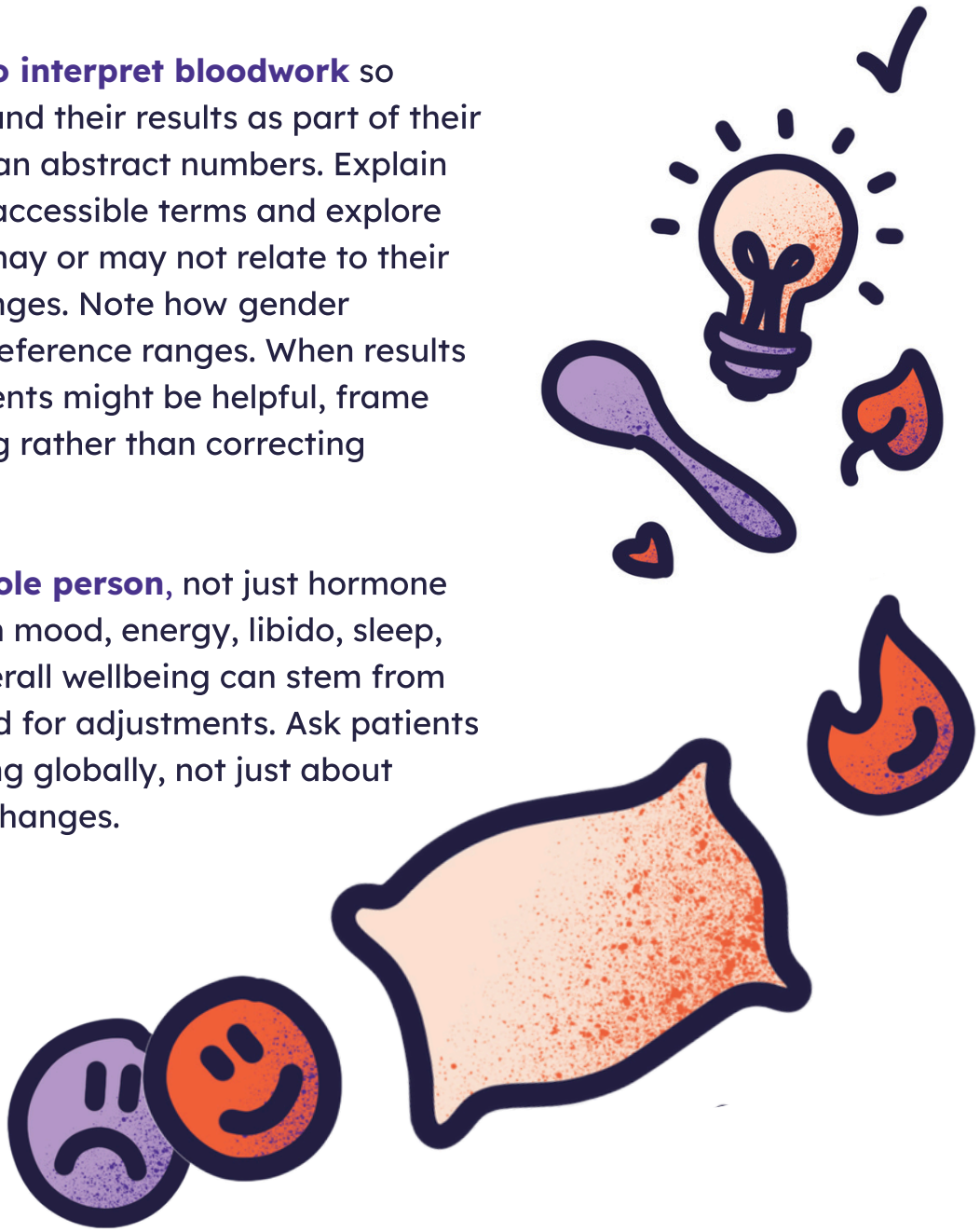
Optimizing timing: Plan collection timing relative to dosing cycles to ensure meaningful results. Midcycle and trough collections are both acceptable—consistency in collection timing relative to dosing is important for meaningful longitudinal interpretation. Advise patients to delay pre-collection doses when possible: taking hormones too close to the draw distorts results.

Reviewing Treatment Progress

Approach progress reviews as collaborative assessments rather than clinical evaluations. Start by acknowledging what's going well—patients often focus on what isn't changing and benefit from discussions about positive developments.

Work together to interpret bloodwork so patients understand their results as part of their journey rather than abstract numbers. Explain target ranges in accessible terms and explore how their levels may or may not relate to their experienced changes. Note how gender markers impact reference ranges. When results suggest adjustments might be helpful, frame this as fine-tuning rather than correcting problems.

Consider the whole person, not just hormone levels. Changes in mood, energy, libido, sleep, appetite, and overall wellbeing can stem from or indicate a need for adjustments. Ask patients how they're feeling globally, not just about gender-specific changes.



When Adjustments Make Sense

As treatment progresses, the patient and provider will continue to learn from experience, outcomes, and changes over time. Some concerns are best met with patience, while others suggest the need for adjustments.

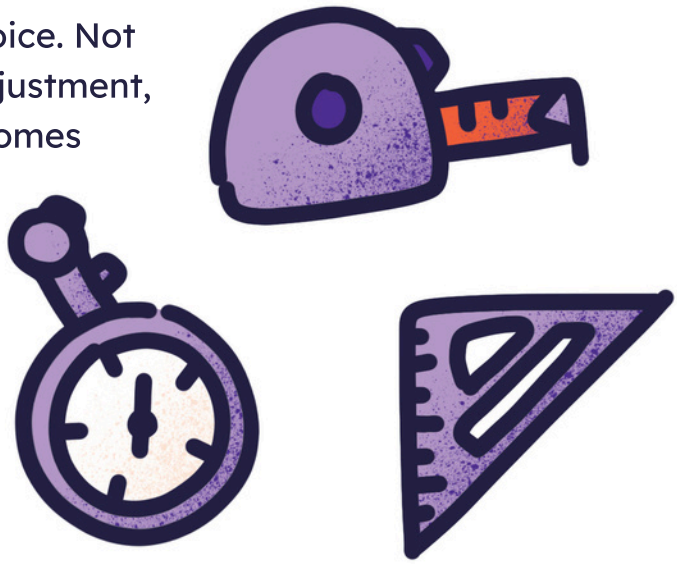
Fine-tuning for optimization occurs when patients are progressing well but could benefit from modest improvements. This might address minor side effects, energy fluctuations, or desire for further progress.

Plateauing is the real or perceived experience of stalled progress and can cause significant patient distress. Discuss experiences and expectations within known variabilities when determining if adjustment is indicated.

Addressing negative effects may be necessary when a patient experiences troublesome side effects or changes to their health status. This may involve more substantial modifications and closer monitoring.

Life changes sometimes necessitate adjustments: new medications, major stress, weight changes, or evolving treatment goals all influence optimal dosing.

Staying the course is also a valid choice. Not every concern requires immediate adjustment, and patience often yields better outcomes and more interpretable data than frequent, reactive changes.



Navigating Differences



You and your patient won't always agree—and that can feel challenging, especially when you're trying to ensure their wellbeing. Preserving the collaborative clinical relationship while navigating differences strengthens trust and lowers the risk of non-adherence and medical avoidance.

Informed consent is an ongoing dialogue. Pause to realign on potential outcomes, risks, and any new responsibilities or commitments for both you and the patient.

Review together outcomes or side effects with expected timelines and efficacy ranges. Reviewing both subjective experiences and clinical expectations grounds the conversation in mutual understanding.

Understand the patient's perspective. What outcomes are falling short? What experiences, values, or concerns shape their intentions?

Reflect on your own clinical approach. Are your concerns based on research, experience, or personal risk tolerances? Consider how your comfort level may differ from theirs, and address that openly.

Plan and monitor in light of any decisions—including staying the course. This might include timelines for watchful waiting, titration, or addressing existing risk factors. Establish expectations for monitoring and re-evaluation, including serious side effects or lab results that may warrant a change to the treatment plan.

Reassure the patient that differing views don't diminish the importance of their perspective, or your commitment to their care. Learning to resolve tension is important to growing your collaborative relationship.

Transition-Related Surgeries

For those considering it, **transition-related surgery (TRS)** is an affirming step toward living authentically. But like any surgery, it also brings complex decisions, logistical challenges, and emotional weight.

A **surgical readiness assessment (SRA)** provides space to explore goals, understand risks and outcomes, and identify the supports patients need throughout the process.

In Newfoundland & Labrador, readiness assessments are also a key step in MCP-covered procedures. This chapter outlines how to navigate the referral process with empathy and clarity, helping patients through the system while affirming and supporting their medical autonomy. It's not a walkthrough of how to conduct a readiness assessment, it's more about understanding the overall shape of the process and who does what.

Transition-Related Surgeries in NL

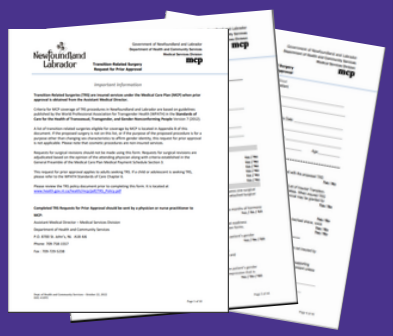
Newfoundland & Labrador's Medical Care Plan provides coverage for a range of transition-related surgeries[19]. These surgeries are an important part of care for many trans, non-binary, and gender-diverse people.

Top surgery coverage exists, but with significant limitations. Procedures include mastectomy with chest masculinization, and breast augmentation when there is no breast development after 12 continuous months of hormone therapy.

Bottom surgery coverage can include both gonadectomy and gender-affirming genital reconstruction. Eligible procedures include genital surgeries such as hysterectomy, salpingo-oopherectomy, and orchiectomy; genital reconstruction such as vaginoplasty, metoidioplasty, and phalloplasty; as well as other associated procedures.

Primary care providers play a key role in supporting patients through this process, including making referrals for surgery. To access MCP coverage, a **Request for Prior Approval** must be completed and submitted by a physician or nurse practitioner.

Our toolkit's appendix (p. 49) includes the full package of forms for the Request for Prior Approval process.



TRS Process

Government of NL TRS Information

1. Initial Planning

Planning for TRS includes discussing the patient's goals for the indicated surgery and reviewing their transition history and current supports. It is also important to confirm MCP coverage and NL residency. The patient should be informed about what is and is not covered by MCP and made aware of the Medical Transportation Assistance Program for out-of-province procedures. Planning then proceeds to determining the name of the surgeon and facility for the proposed TRS procedure. This information will be required for subsequent approval.

2. Surgical Readiness Assessment

MCP requires one SRA for chest surgeries and two for genital surgeries. An SRA must be completed by a qualified assessor, as defined on the Surgical Readiness Assessor Certification and Recommendation Form, included at the end of this resource and based on the WPATH Standards of Care.

3. Request for Prior Approval

Referrals for TRS procedures require prior approval from MCP. The TRS Prior Approval Request package includes:

- a Patient Information Sheet to be completed by the patient
- a Clinical Eligibility for TRS section to be completed by the primary care provider (physician or nurse practitioner)
- one or two single-page SRAs completed by qualified assessors

TRS Process



4. Submit Prior Approval Request to MCP

The Department of Health and Community Services (Medical Services Division) reviews the TRS Request for Prior Approval.

5. Refer to Surgeon



Once the request is approved, the surgical referral can be made. The patient may need support in communicating with the surgeon or clinical intake staff. They may also need support with Medical Transportation Assistance Program travel request forms.

6. Pre-op Coordination

The patient may need additional pre-operative support, depending on the procedure and surgeon requirements, and coordination between the primary care provider and surgeon ensures continuous care.

7. Post-op Coordination

Once the surgery date is set, referrals can be made to public health for wound care. Post-surgical complications may also require the primary care provider to coordinate with the surgical clinic.



Post-operative Care

Most TRS procedures are performed out-of-province, resulting in at least some disruption of continuity in post-operative care. Care therefore requires coordination among multiple departments, including the surgical clinic, wound care nurses, and the primary care provider.

Depending on the procedure and patient, patients may also benefit from information on self-monitoring for complications; information on post-surgical health, including managing patient expectations regarding healing, nerve regeneration, and alleviation of gender dysphoria; and more general information on additional supports and resources.

Patient adherence to post-operative directions is essential, and follow-up may be indicated at future appointments. For example, for vaginoplasty patients, the vagina requires regular dilations according to a schedule prescribed by the surgeon. Omission of these dilations will result in stenosis of the vagina with risks of infection or closure, requiring additional surgery. Dilation can be uncomfortable and difficult for some patients, increasing the short- and medium-term risk of non-adherence. The need to continue dilations for life may also pose a long-term risk of non-adherence, even years after the procedure.



Limitations of Current Coverage

While Newfoundland & Labrador provides some coverage for gender-affirming care through MCP, there are still significant gaps and limitations that can delay or prevent access to necessary surgeries and supports.

Restrictive Criteria for Breast Augmentation Coverage

Top surgery coverage for assigned male at birth patients is effectively non-existent: requiring the exceedingly rare result of no breast growth (aplasia) after 12 months of hormone therapy.

Some patients do not need, want, or are able to undergo hormone therapy, and outcomes vary widely even for those on HRT. Patients without complete aplasia may still have insufficient breast development and require top surgery as a part their gender transition.



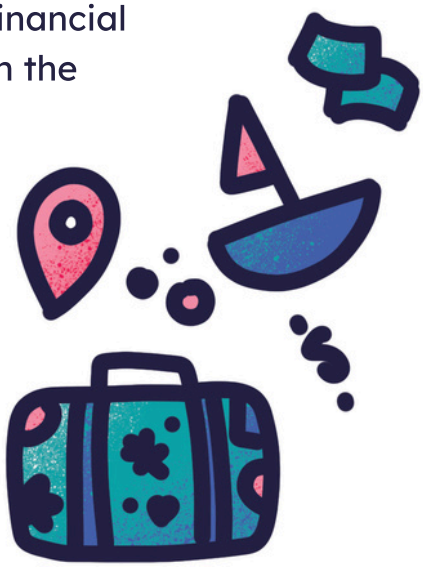
Incomplete Coverage for Top Surgery

MCP covers only some of the necessary components of top surgery for assigned female at birth patients. The removal of breast tissue (mastectomy) and basic chest masculinization are covered, but liposuction is not. Depending on the patient's body, these procedures are often essential for achieving affirming results[10]. Without full coverage, many patients are left paying thousands of dollars out of pocket or unable to access surgery at all.

Out-of-Province Referrals

Many procedures are not currently performed within the province. Mastectomy, chest masculinization, and all bottom surgeries can only be accessed through referrals to out-of-province providers. This creates major logistical and financial barriers, including travel costs.

For most surgeries it is recommended to have a support person to travel with the patient for safety and post-operative care. This can be difficult to arrange, especially for those with limited social or financial supports. Limited travel supports are available through the Medical Transportation Assistance Program.



Travel involves a range of significant challenges, particularly during recovery periods requiring lengthy out-of-province accommodations which may not be entirely covered under the Medical Transportation Assistance Program.

Limited Access Despite MCP Coverage

While MCP offers some coverage for gender-affirming care, many people are still unable to access these supports due to a lack of primary care providers who offer this care. Without a knowledgeable and affirming provider to guide them through referrals, assessments, and treatment options, individuals are often left in limbo, eligible for coverage on paper but unable to move forward in practice. This gap especially impacts people in rural areas, where provider options are already limited. As a result, many are forced to delay care, travel long distances, or go without support altogether.

Rainbow Health Ontario Guidelines for Gender-Affirming Primary Care

Providers should familiarize themselves with a comprehensive, Canadian-based set of GAC guidelines. With permission from Rainbow Health Ontario and the author, Dr. Amy Bourns, we have included RHO's quick reference guide for easy access. More comprehensive information can be found in their full guide or through their Trans Primary Care interactive website.

RHO - Guidelines for Gender-affirming Primary Care

RHO - Trans Primary Care interactive website

sherbourne HEALTH | rainbow health ontario SHERBOURNE HEALTH

guidelines for gender-affirming primary care with trans and non-binary patients

A QUICK REFERENCE GUIDE FOR PRIMARY CARE PROVIDERS (PCPs)

This quick reference guide was derived from Sherbourne's *Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients* and is designed to be used in conjunction with the full Guidelines.

Key messages

- Prescribing hormone therapy for trans patients is well-situated in primary care.
- The risks of witholding hormone therapy are often more substantial than the risks of treatment.

AN INDIVIDUALIZED APPROACH

Given the spectrum of gender identity and the variation in each person's expression, there is no single pathway for a trans person to follow in order to actualize the presentation of their authentic self. Non-binary patients may also seek hormone therapy to modify their secondary sex characteristics.

When hormones are chosen as part of transition, some patients may seek maximum feminization/masculinization, while others may seek a more androgynous appearance.

DECISION TO INITIATE HORMONE THERAPY

The decision to initiate hormone therapy is a collaborative patient-centered process that focuses on both psychosocial preparation and informed consent. The PCP (with or without the support of a multi-disciplinary team) can facilitate a decision-making process that informs, educates and supports patients. For each patient seeking hormone therapy, it is important to not only consider the possible risks of treatment but to consider the often substantial risks of witholding treatment.

TERMINOLOGY

CIS: Refers to a state of alignment of one's gender identity with the gender assigned at birth. You may also sometimes see "cissexual" or "cisgender." Thus, non-trans men are "cis men" and non-trans women are "cis women." It is preferable (and more accurate) to use "cis" than to use terms such as "bio", "genetic" or "real." It is also preferable to use "cis" rather than only using "woman" or "man" to describe non-trans persons. If cis is not used as a descriptor for non-trans persons, then such persons may be presumed to be the more "normal" or "valid" instantiation of that particular gender, thus contributing to cissexism.

TRANS: Umbrella term for people who are not cis, includes persons who are (or identify as) non-binary as well as transmasculine and transfeminine individuals.

NON-BINARY: Umbrella term for anyone who does not identify with static, binary gender identities. Includes persons who may identify as having an intermediary gender (e.g. genderqueer), as being multiple genders (e.g. bigender, polygender, etc.), as having a shifting gender (gender fluid), or as not having a gender altogether (agender).

DISCLAIMER:

These guidelines reflect the current practice at Sherbourne Health in the management of trans patients. We do not present it as a 'Standard of Care' but instead as a guide to help clinicians in their day-to-day practice. Adaptions may be considered relating to each patient's unique circumstances. Clinicians must use their own expertise and decision-making skills within each clinical encounter.

Feminizing hormone therapy

The goal of hormone therapy in transfeminine patients is to reduce the endogenous effects of testosterone and to induce feminine secondary sex characteristics. Physiologically, this requires a suppression of endogenous androgens and the addition of estrogen. This treatment results in both reversible and irreversible feminization.[1]

ANTI-ANDROGENS

The anti-androgens typically used at Sherbourne Health are spironolactone and cyproterone, with the former historically chosen preferentially as it was believed to have a superior safety profile. This practice has changed over time, as adequate anti-androgen effects and testosterone suppression into the female range are achievable at lower doses of cyproterone (i.e. 12.5 – 25mg daily) at which adverse effects are less likely.[2] Thus the choice of anti-androgen should be made individually for each patient based on their medical history and preference regarding risk and side effect profiles. Following orchiectomy (+/- vaginoplasty), most transfeminine patients will not require androgen suppression. The androgen-blocker can be stopped immediately after surgery or tapered over the course of 4-6 weeks or more depending on individual factors (e.g., patients with hypertension or renal dysfunction on spironolactone should be tapered).

ESTROGENS

Estrogen acts directly on estrogen receptors to initiate feminization. Several forms and routes of estrogen have been used for feminization. At Sherbourne Health, the most common form used is oral 17-β estradiol (Estrace), which is covered by the ODB program. While conjugated estrogens (e.g. Premarin) have historically been used due to their accessibility/affordability, they are no longer recommended.[3] There is a lack of consensus on the preferred timing of the initiation of estrogens in relation to an anti-androgen. Common approaches have included both the initiation of an anti-androgen (usually 1-3 months) prior to the addition of estrogen, or alternatively, the simultaneous introduction and subsequent titration of both components. In patients over 50 years old who have been on estrogen for several years, doses may be reduced to those administered to post-menopausal cis women (e.g. starting/low dose topical formulations).

Keep in mind: In adolescent patients, the initiation of estrogen therapy prior to the completion of skeletal growth may lead to an earlier cessation of long bone growth and thus shorter adult height, an effect which would be irreversible. This may be a desired effect. Complete epiphyseal fusion can occur as early as age 14 and as late as age 19 in AMAB individuals.[4]

PRECAUTIONS

Evidence compiled by the Endocrine Society suggests that feminizing hormone therapy is "**safe without a large risk of adverse events when followed carefully for a few well-documented medical concerns.**"[5]
Available measures to reduce risks associated with feminizing hormone therapy should be considered and discussed with patients and if possible, undertaken prior to or concurrently with hormone therapy.[6] Suggested measures to minimize risks associated with precautions may be found in the full Guidelines.

Contraindications

- Unstable ischemic cardiovascular disease
- Estrogen-dependent cancer
- End stage chronic liver disease
- Psychiatric conditions which limit the ability to provide informed consent
- Hypersensitivity to one of the components of the formulation

FORMULATIONS AND RECOMMENDED DOSES OF ANTI-ANDROGENS AND ESTROGEN

Formulations	Starting Dose	Usual Dose	Maximum Dose	Cost* (4 weeks)
Spironolactone (oral)	50 mg daily - BID	100 mg BID	150 mg bid[a]	$15–$41
Cyproterone (oral)	12.5 mg (1/4 50 mg tab) q2d - daily	12.5 mg (1/4 50 mg tab) – 25 mg (1/2 50 mg tab) daily	50 mg daily[a]	$16–$56
Estradiol (oral)*	1–2mg daily	4mg daily or 2mg bid	6 mg daily or 3 mg BID	$18–$54
Estradiol (transdermal, patch)*[b]	50 mcg daily/apply patch 2x/ week	Variable[c]	200 mcg daily/ apply patch 2x/ week	$39–$76[d]
Estradiol (transdermal, gel)*[e]	2.5 g daily (2 pumps, contains 150 mcg estradiol)	Variable[c]	6.25 g OD (5 pumps, contains 375 mcg estradiol), may be limited by surface area requirements for gel application	$58–$154
Estradiol valerate** Injectable (IM)[f]	3–4 mg q weekly or 6–8 mg q 2 weeks	Variable[c]	10mg q weekly	$36–$46

** Price quotes are provided by www.pharmacy.ca. The above prices are accurate as of May 2018 and represent the price for a 4-weeks supply of a generic brand of medication unless indicated otherwise (ranging from low dose to maximum dose). Prices include a usual and customary dispensing fee of $9.99, which may vary from pharmacy to pharmacy.* **Note: For patients on ODB, spironolactone, cyproterone, and oral estradiol are covered without the submission of an EAP form.**
*** Estradiol valerate IM must be prepared by a compounding pharmacy, price quote provided by Pace Pharmacy (including $10.99 dispensing fee)*
a) *rarely required or used. Maximal effect does not necessarily require maximal dosing. Use clinical judgement in selecting optimal individual dosing;* ***b)*** *Estradot® brand;* ***c)*** *Usual doses vary significantly between individuals. Use starting doses and titrate up based on patient response. Maximum doses are not often needed. Use clinical judgement in selecting optimal individual dosing;* ***d)*** *200 mcg daily given as 2x100 mcg patches applied twice weekly (4 patches/week);* ***e)*** *Estragel® brand* ***f)*** *Estradiol valerate IM must be prepared by a compounding pharmacy, commonly at the minimum concentration of 10mg/mL. Per updated Ontario guidelines, opened multi-use vials must be discarded after 28 days.*

SAFETY

Transdermal estradiol seems to be less thrombogenic than oral estradiol with fewer hepatic side effects and is thus recommended for patients over 40 or with risk factors for cardiovascular, thromboembolic, or liver disease.[7]

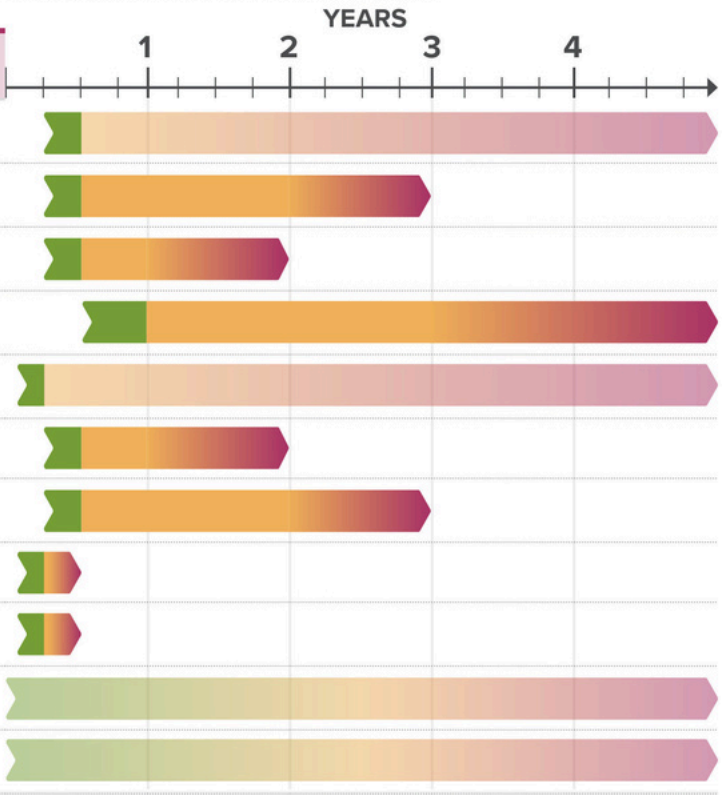
PREVENTIVE CARE

Transfeminine patients maintained on feminizing hormone therapy have unique preventive care needs and recommendations. An adapted ***Preventive Care Checklist*** for transfeminine patients that can be used at the point of care can be found in the full Guidelines.

EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES

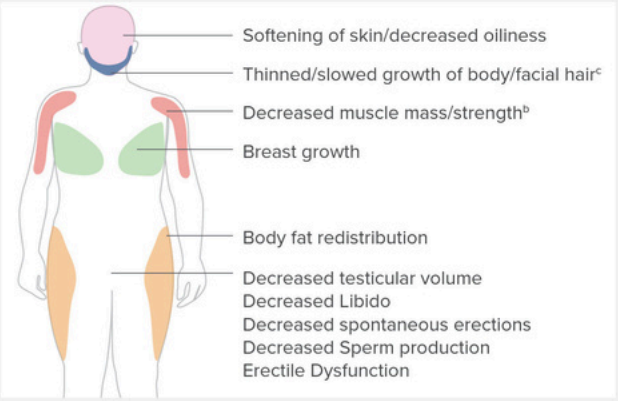
The degree and rate of physical effects are largely dependent on patient-specific factors such as age, genetics, body habitus and lifestyle, and to some extent the dose and route used (selected in accordance with a patient's specific goals and risk profile).[8]

Physical Effects	Reversibility	Onset[a]	Expected maximal effect[a]
Softening of skin/ decreased oiliness	Reversible	3-6 months	Unknown
Body fat redistribution	Reversible/ Variable	3-6 months	2-3 years
Decreased muscle mass/strength[b]	Reversible	3-6 months	1-2 years
Thinned/slowed growth of body/facial hair[c]	Reversible	6-12 months	>3 years
Scalp hair loss (loss stops, no regrowth)	Reversible	1-3 months	Variable
Breast growth	Irreversible	3-6 months	1-2 years
Decreased testicular volume	Variable	3-6 months	2-3 years
Decreased libido	Variable	1-3 months	3-6 months
Decreased spontaneous erections	Variable	1-3 months	3-6 months
Decreased sperm production	Variable	Variable	Variable
Reduced erectile function	Variable	Variable	Variable



Keep in mind: Use patient preferred terminology. "Testicular" and "erections" may be upsetting to some but not all. Physical changes related to androgen blockade and estrogen may take months to appear and are generally considered to be complete after 2-3 years on hormone therapy. Breast growth is an aspect of feminization to which many transfeminine patients assign great importance. The degree of breast development is dependent on many factors, but most transfeminine patients experience modest breast development (average cup size <A, at a developmental Tanner stage of 2-3).[9, 10] Feminizing therapy does not affect the pitch of the voice in transfeminine patients.

a) Estimates represent unpublished clinical and published observations[11,12,13]
b) Significantly dependent on amount of exercise;
c) Complete removal of facial hair requires electrolysis, laser treatment, or both



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Visual reference: Tetzlaff K.Patient's guide to transgender, trans, & gender diverse health. 2015. https://ktetzlaffdotcom.files.wordpress.com/2015/01/ tetzlaff_transhealthbooklet1.pdf

MONITORING STRATEGIES & DOSE ADJUSTMENTS

- Standard monitoring of a feminizing hormone regimen should be employed at baseline, 3, 6, and 12 months; and yearly thereafter (creatinine and electrolytes should be checked 4-6 weeks after the initiation or dose increase of spironolactone).
- Some providers prefer to see patients monthly until an effective dose is established. Follow up visits should include a functional inquiry, targeted physical exam, bloodwork, and health promotion/disease prevention counselling as indicated.
- Dose titration of an anti-androgen and estrogen may be performed over the course of 3-6 months or more and will depend on patient goals, physical response, measured serum hormone levels, and other lab results.
- For many transfeminine patients, the goal will be to achieve the suppression of testosterone into the female range. Hormone levels for those seeking a more androgynous appearance may intentionally be mid-range between male and female norms.
- Measurement of total testosterone is adequate to assess the degree of androgen suppression, without the routine need for free testosterone levels. Be mindful that patients may have clinically relevant results without complete suppression of testosterone because of androgen blockade, which is not measurable.
- Serum estradiol levels should also be monitored. Most patients attain considerable feminization at estradiol levels between 200-500 pmol/L.

Keep in mind:
Clinical effects are the goal of therapy, not specific lab values. If the sex marker associated with the patient's health card has not been changed, the reported reference ranges will refer to the sex assigned at birth. Reference ranges vary between laboratories - refer to reference ranges from the specific laboratory (often available online or by request from the lab).

HORMONE MONITORING SUMMARY FOR TRANSFEMININE PATIENTS

In this table, smaller and lighter grey checkmarks indicate parameters that are measured under particular circumstances.
NB: Individual parameters should be considered more frequently if concerns identified or existing risk factors are present.

Non-hormone labs:

- **Hemoglobin/Hematocrit** - use female reference for lower limit of normal and male reference for upper limit of normal
- **Creatinine** - use male reference for upper limit of normal.

	Baseline	Month 3	Month 6	Month 12[e]	Yearly	According to guidelines for cis patients, or provider discretion
Exam/ Investigations	Focused Physical Exam. Include: height, weight, BP, +/- breast inspection/ measurement(s)*	BP, weight, +/- breast inspection/ measurement(s) at 12 months*			See Preventive care checklist for transfeminine patients and Accompanying Explanations in the full Guidelines.	
BLOODWORK						
CBC[a]	✓	✓	✓	✓	✓	
ALT[b]	✓	✓	✓	✓	✓	✓
Creatinine/Lytes[c]	✓	✓	✓	✓	✓	
HbA1c or Fasting Glucose	✓			✓		✓
Lipid profile	✓			✓		✓
Total Testosterone	✓	✓	✓	✓	✓	
Estradiol	✓	✓	✓	✓	✓	
Prolactin[d]	✓			✓	✓	✓
Other	Hep B and C					
	Consider: HIV, syphilis, and other STI screening as indicated, frequency depending on risk					

** for patients who may have interest in OHIP-covered breast augmentation surgery, perform breast inspection at baseline and 12 months with particular attention to Tanner stage. Chest circumference at fullest part of the breast and areolar diameter may be helpful in determining the presence or absence of breast growth*
a) at baseline for all, and regularly with cyproterone
b) at baseline for all and regularly with cyproterone, otherwise repeat once at 6-12 months then as needed
c) Cr and lytes should be monitored at each visit with spironolactone (including 2-6 weeks after starting), but is only required at baseline and then once between 6-12 months with cyproterone unless risk factors or concerns re: renal disease are present
d) Prolactin should be monitored at least yearly with the use of cyproterone, and more frequently if elevation is noted
e) during first year of treatment only

This Quick Reference Guide for pimary care providers was authored by Dr. Amy Bourns and produced by Rainbow Health Ontario, a program of Sherbourne Health, to accompany the ***Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients, 4th edition.***

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Masculinizing hormone therapy

The cornerstone of hormone therapy for transmasculine patients is testosterone. The goal of treatment is virilization – the development of masculine secondary sex characteristics. This treatment results in both reversible and irreversible masculinization.

TESTOSTERONE

In Ontario, options for testosterone administration include injectable and transdermal preparations (patch or gel). Injectable formulations are most commonly used, due to their superior efficacy and affordability. While intramuscular (IM) injection is the most common means of administering parenteral testosterone, subcutaneous (SC) delivery has also been used with clinical efficacy and is very well-tolerated. A dose reduction of 10-15% can be considered if switching from IM to SC.

PRECAUTIONS

Evidence compiled by the Endocrine Society suggests that masculinizing hormone therapy is "**safe without a large risk of adverse events when followed carefully for a few well-documented medical concerns**".[1] Available measures to reduce associated risks should be considered and discussed with patients and if possible, undertaken prior to or concurrently with the initiation of hormone therapy. Suggested measures to minimize risk associated with known precautions may be found in the full Guidelines.

Contraindications

- Pregnancy or breast feeding
- Active known sex-hormone-sensitive cancer (e.g., breast, endometrial)
- Unstable ischemic cardiovascular disease
- Poorly controlled psychosis or acute homicidality
- Psychiatric conditions which limit the ability to provide informed consent
- Hypersensitivity to one of the components of the formulation

SAFETY

Gel formulations have the risk of inadvertent exposures to others who come into contact with the patient's skin. This is of particular importance for patients with young children and/or with intimate partners who are pregnant or considering pregnancy.

Keep in mind:
Testosterone therapy does not prevent pregnancy even if amenorrhea is achieved. Testosterone is a teratogen thus reliable contraception may be required depending on sexual practices.

PREVENTIVE CARE

Transmasculine patients maintained on masculinizing hormone therapy have unique preventive care needs and recommendations. An adapted *Preventive Care Checklist* for transmasculine patients that can be used at the point of care can be found in the full Guidelines.

FORMULATIONS AND RECOMMENDED DOSES OF TESTOSTERONE

Formulations	Starting Dose	Maximum Dose	Cost per unit*	Approx. Cost* (4 weeks)
Testosterone enanthate (IM/SC)[a]	20–50 mg q weekly or 40–100 mg q 2 weeks	100 mg q weekly or 200 mg q 2 weeks	$73.50 per 5mL vial (each vial contains 200 mg/mL x 5 mL = 1000 mg)	$14–$29 (covered by ODB with EAP request)
Testosterone cypionate (IM/SC)[a]			$64 per 10 mL vial (each vial contains 100 mg/mL x 10 mL = 1000 mg)	$13–$26 (covered by ODB with EAP request)
Testosterone path (transdermal)[b]	2.5–5 mg daily	5–10 mg daily	$164 / 60 x 2.5 mg patches $169 / 30 x 5 mg patches	$76.50–$315
Testosterone Gel 1% (transdermal)	2.5–5 g daily (2–4 pumps, equivalent to 25–50 mg testosterone)	5–10 g daily (4–8 pumps, equivalent to 50–100 mg testosterone)	$67 / 30 x 2.5 g sachets $110 / 30 x 5g sachets $175 / 2 pump bottles[c]	Sachets: $62–$205 Bottles: $81–$327

** Price quotes provided by www.pharmacy.ca. The prices listed above are accurate as of June 2018 and represent the price of the generic brand of medication unless otherwise indicated (ranging from low dose to maximum dose). Prices include a usual and customary dispensing fee of $9 99, which may vary from pharmacy to pharmacy.*

a) Testosterone enanthate is compounded in sesame oil, and testosterone cypionate is compounded in cottonseed oil; patients with allergy to either of these compounds should use the alternative agent

b) Androderm brand, per drug monograph the 12.2 mg patch delivers 2.5 mg/day while the 24.3 mg patch delivers 5 mg per day

c) Each pump bottle provides 60 pumps, 1 pump = 1.25 g of gel, equivalent to 12.5 mg of testosterone

NB: Testosterone (in all forms) is considered a controlled substance in Canada; prescriptions should be written in accordance with provincial requirements for controlled substances.

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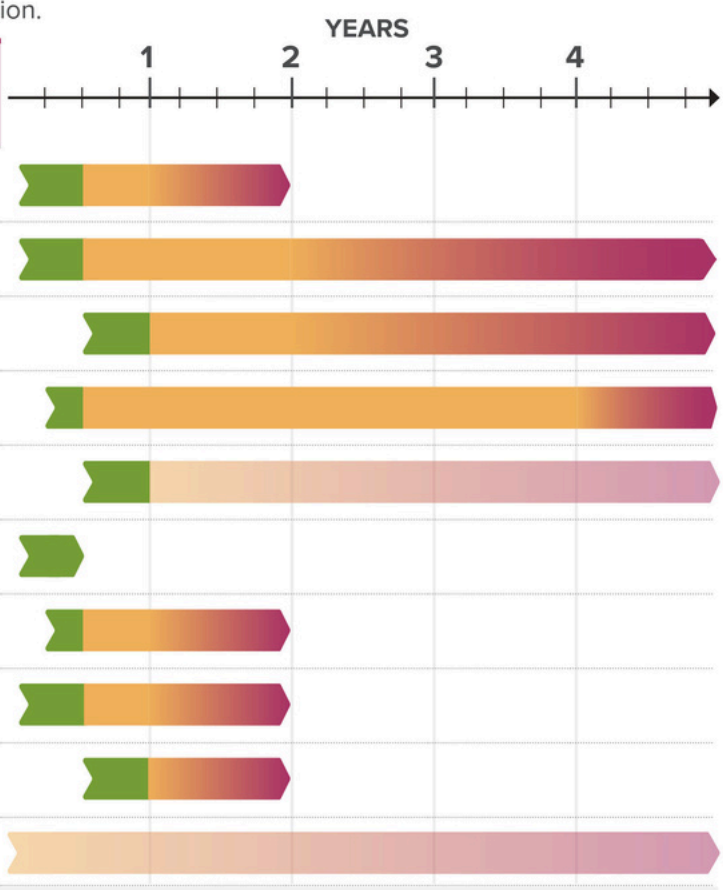
EFFECTS AND EXPECTED TIME COURSE OF TESTOSTERONE

The degree and rate of physical effects is dependent on the dose and route of administration,[2] as well as patient-specific factors such as age, genetics, body habitus and lifestyle. Hormone therapy results in both reversible and irreversible masculinization.

Physical Effects	Reversibility	Onset[a]	Expected maximal effect[a]
Skin oiliness/acne	Reversible	1-6 months	1-2 years
Body fat redistribution	Reversible/ Variable	1-6 months	2-5 years
Increased muscle mass/strength[b]	Reversible	6-12 months	2-5 years
Facial/body hair growth	Irreversible	3-6 months	4-5 years
Scalp hair loss	Irreversible	6-12 months[c]	Variable
Cessation of menses	Reversible	1-6 months	n/a
Clitoral enlargement	Irreversible	3-6 months	1-2 years
Vaginal Atrophy	Reversible	1-6 months	1-2 years
Deepened voice	Irreversible	6-12 months	1-2 years
Infertility	Variable	Variable	Variable

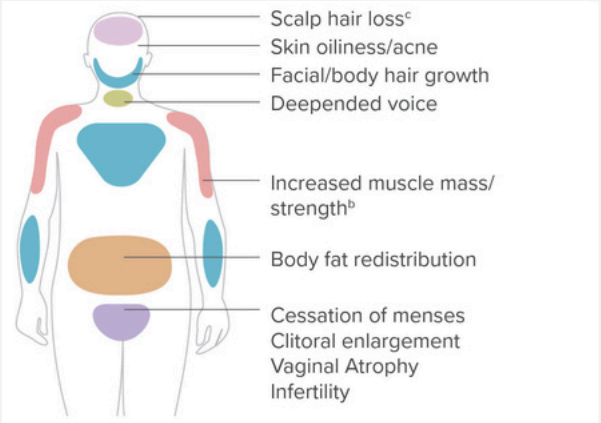


Keep in mind:

Use patient-preferred terminology. Terminology such as “clitoral” and “vaginal” may be upsetting to some but not all.

Desired androgenic effects of testosterone therapy include deepened voice, cessation of menses, clitoral growth, increased muscle mass, and hair growth in androgen dependent areas including facial hair. Breast tissue may lose glandularity, but generally does not lose mass or hemi circumference. Typically, patients taking testosterone will experience masculinizing changes over a period of months to years. The timeframe of physiologic changes may be slightly slower with the use of transdermal preparations.

a) Estimates represent published and unpublished clinical observations[3-6]
b) Significantly dependent on amount of exercise
c) Highly dependent on age and inheritance; may be minimal



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MONITORING STRATEGIES & DOSE ADJUSTMENTS

- Standard monitoring of testosterone should be employed at baseline, 3, 6, and 12 months; and yearly thereafter.
- Some clinicians prefer to see patients monthly until an effective dose is established.
- Follow up visits should include a functional inquiry, targeted physical exam, blood work, and health promotion/disease prevention counselling as indicated.
- Titration of doses will generally occur in the early phases of treatment. For example, with injectable testosterone, a starting dose of 30 mg injected weekly could be increased by 10–20 mg every 4–6 weeks. Speed of titration will depend on lab results, patient goals, response, and side effects.
- For those using an injectable route, there may be utility in varying the timing of blood work to gather information regarding serum hormone levels throughout the cycle (peak, mid-cycle, and trough), especially if a patient is reporting cyclic symptoms.
- Hormone levels for those seeking a more androgynous appearance may intentionally be mid-range between male and female norms.
- Supraphysiologic levels should be avoided due to the increased risk of adverse events and side effects, as well the potential for the aromatization of excess testosterone into estrogen. Dose reduction is warranted if supraphysiologic doses are measured at mid-cycle or trough.
- There may be some irregular bleeding or spotting in the first few months of treatment. However, once sustained menstrual cessation is achieved, any vaginal bleeding without explanation (e.g. missed dose(s) or lowered dose of testosterone) warrants a full workup for endometrial hyperplasia/cancer.

Keep in mind:
Clinical effects are the goal of therapy, not specific lab values. If the sex marker associated with the patient's health card has not been changed, the reported reference ranges will refer to the sex assigned at birth. Reference ranges vary between laboratories - refer to reference ranges from the specific laboratory (often available online or by request from the lab).

HORMONE MONITORING SUMMARY FOR TRANSMASCULINE PATIENTS

In this table, smaller and lighter grey checkmarks indicate parameters that are measured under particular circumstances.

Non-hormone labs:
Male reference ranges should be used for Hb/Hct (lower limit of female range can be used if menstruating).

	Baseline	Month 3	Month 6	Month 12[b,c]	Yearly	According to guidelines for cis patients, or provider discretion
Exam/ Investigations	Focused Physical Exam with PAP if indicated. Include: height, weight, BP.	BP, weight			See ***Preventive Care Checklist for Transmasculine Patients*** and accompanying explanations in the ***Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients.***	
BLOODWORK						
CBC	✓	✓	✓	✓	✓	
ALT	✓		✓[c]			✓
HbA1c or Fasting Glucose	✓		✓[c]			✓
Lipid profile	✓		✓[c]			✓
Total Testosterone	✓	✓	✓	✓	✓	
LH[a]	✓			✓	✓	

NB: Individual parameters should be considered more frequently if concerns identified or existing factors are present
a) Post-gonadectomy: Elevated LH may have implications regarding bone mineral density (See full Guidelines)
b) During first year of treatment only
c) Once at either 6- or 12-month mark

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2023 medication updates to sherbourne's guidelines

FOR GENDER-AFFIRMING PRIMARY CARE WITH TRANS AND NON-BINARY PATIENTS

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CYPROTERONE and risk of meningioma

In addition to the risks and side effects of cyproterone already covered herein, concern is emerging that prolonged use of high-dose cyproterone may be associated with the development of meningiomas.

Meningiomas are rare, most-often benign, tumours of the meninges (membranes covering the brain and spinal cord). Observations of increased incidence in cis women compared with cis men as well as the histological presence of progesterone (and to a lesser degree estrogen) receptors suggest that these tumours are hormone-sensitive.

Meningiomas may present with singular or multiple lesions which are often extremely slow-growing, and as such can remain asymptomatic for many years. Due to their location they may ultimately cause clinically significant symptoms such as headaches, focal neurologic symptoms, mental status changes and seizures. Symptomatic meningiomas may require neurosurgical resection if feasible.

Nine cases of meningioma(s) in transfeminine individuals have been reported in the literature, in whom eight of nine were using cyproterone and seven of nine were using a high dose (50-100 mg) for at least four years.[1,2]

A retrospective study of 2,555 trans women primarily using high dose (50-100 mg) cyproterone for many years following gonadectomy identified an increased standardized incidence ratio compared with the general population (4.1 compared with cis women and 11.9 compared with cis men).[3]

Based on the available data in cis populations using cyproterone, the European Medicines Agency released a statement in 2020 asserting that the risk of meningioma appears to rise with increasing cumulative doses, primarily occurring at doses >25 mg/day. They recommended that doses >10 mg be restricted to certain uses but did not make any recommendation on dose limits for gender-affirming purposes.[4]

WPATH's updated Standards of Care (SOC-8) acknowledges that there may be some concerns with prolonged use (>2 years) and higher doses (>10 mg daily) of cyproterone. They appear to recommend a maximum dose of 10 mg in Table 4, Appendix C, citing a 2021 prospective cohort study's[5] findings that the 10 mg dose provides comparable efficacy (suppression of serum testosterone into the usual range for cis women) with less adverse effects than higher doses. Importantly, however, they conclude that there is insufficient evidence to recommend the use of one androgen blocker over another.[6]

While further research is needed to demonstrate conclusive evidence of a causative relationship between cyproterone and meningioma, the following recommendations can be considered:

- The possibility of increased risk of meningioma with cyproterone should be included in the informed consent discussion with patients choosing an androgen blocker, as well as reviewed in those who have been on >10 mg for >2 years
- If resources exist to compound medications, a lower initial dose of cyproterone can be considered (eg. 2.5-5 mg), with the use of doses >10 mg limited to those with inadequate response to lower doses
- When compounding is not an option, tablets may be quartered to obtain a 12.5 mg dose [a]
- Those using cyproterone (particularly at doses >10 mg for >2 years) should be aware of and monitored for signs and symptoms of meningioma including: changes in vision, hearing loss or ringing in the ears, loss of smell, headaches, memory loss, seizures or weakness in the arms and legs
- No routine screening for meningioma is recommended for asymptomatic patients, regardless of dose/duration
- In those who present with symptoms concerning for meningioma, MRI or CT of the brain (and spinal cord if spinal meningioma is suspected) is recommended[7]
- As previously noted in these guidelines, personal history of meningioma should be considered a contraindication to cyproterone
- Cyproterone should be discontinued permanently if meningioma is identified
- Any plan for the ongoing use of higher doses of cyproterone following gonadectomy should be reconsidered given that the balance of potential risks and benefits is unlikely to favour its use in this setting

NOTE: Major adverse events remain uncommon even in those using long-term and higher-dose cyproterone.

[a] *Commercially available cyproterone in Canada is available only in a 50 mg tablet. Accounting for medication lost during the splitting process, quartering may in fact result in an average dose closer to 10 mg.*

updates,continued

TESTOSTERONE PATCHES

Testosterone patches were discontinued in 2021 and are no longer available.

ETONOGESTREL SUBDERMAL IMPLANT

The availability of the etonogestrel implant (Nexplanon) offers an additional option for contraception in transmasculine individuals. However, the common side effect of irregular spotting may limit its utility for menstrual cessation, particularly in the absence of exogenous testosterone administration.

FINASTERIDE

The benefit of 5-alpha-reductase inhibitors for the treatment of androgenic alopecia in transmasculine individuals should be balanced with the possibility of impairment of both clitoral growth and the development of facial and body hair.[6]

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this update added November 2023 by Rainbow Health Ontario

NL Transition-Related Surgery Resources

The Department of Health and Community Services oversees patient referrals for transition-related surgeries. The Department's 10-page TRS Request for Prior Approval package follows below.

It contains essential information, including appendices on the WPATH-recommended content of the Surgical Readiness Assessment and details concerning which procedures MCP does and does not cover.

Transition-Related Surgery
Request for Prior Approval

Important Information

Transition-Related Surgeries (TRS) are insured services under the Medical Care Plan (MCP) when prior approval is obtained from the Assistant Medical Director.

Criteria for MCP coverage of TRS procedures in Newfoundland and Labrador are based on guidelines published by the World Professional Association for Transgender Health (WPATH) in the **Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People** Version 7 (2012).

A list of transition-related surgeries eligible for coverage by MCP is located in Appendix B of this document. If the proposed surgery is not on this list, or if the purpose of the proposed procedure is for a purpose other than changing sex characteristics to affirm gender identity, this request for prior approval is not applicable. Please note that cosmetic procedures are non-insured services.

Requests for surgical revisions should not be made using this form. Requests for surgical revisions are adjudicated based on the opinion of the attending physician along with criteria established in the General Preamble of the Medical Care Plan Medical Payment Schedule Section 3.

This request for prior approval applies to adults seeking TRS. If a child or adolescent is seeking TRS, please refer to the WPATH Standards of Care Chapter 6.

Please review the TRS policy document prior to completing this form. It is located at www.health.gov.nl.ca/health/mcp/pdf/TRS_Policy.pdf

Completed TRS Requests for Prior Approval should be sent by a physician or nurse practitioner to MCP:

Assistant Medical Director – Medical Services Division

Department of Health and Community Services

P.O. 8700 St. John's, NL A1B 4J6

Phone: 709-758-1557

Fax : 709-729-5238

Check List

- ☐ **Patient has completed all sections of the *Patient Information Sheet.***
- ☐ **A physician or nurse practitioner has completed the section on *Clinical Eligibility for TRS*.**
- ☐ **One Surgical Readiness Assessment with a signed *Surgical Readiness Assessor Certification and Recommendation* form is attached**

  OR

- ☐ **Two Surgical Readiness Assessments (required for genital surgeries) with two signed *Surgical Readiness Assessor Certification and Recommendation* forms is attached.**

Transition-Related Surgery
Request for Prior Approval

Instructions

Application to be submitted by a physician/nurse practitioner

Instructions:

- HCS must approve this request prior to the patient receiving surgery in order to ensure MCP funding for TRS patients.

- The patient must complete and sign the *Patient Information Sheet* (page 4).

- Only physicians and nurse practitioners can submit a TRS Request for Prior Approval. The physician or nurse practitioner submitting this request must:
  i. complete *Clinical Eligibility for TRS* (pages 5-7);
  ii. include a copy of the surgical readiness assessment(s) and the Surgical Readiness Assessor Certification and Recommendation form(s); and
  iii. submit the completed application to the Assistant Medical Director at the Department of Health and Community Services (HCS);

For genital surgery, a second practitioner who also meets the requirements set out in the *Surgical Readiness Assessor Certification and Recommendation* form must provide a second surgical readiness assessment along with the *Surgical Readiness Assessor Certification and Recommendation* form. (Two surgical readiness assessment letters are required for all TRS genital surgeries).

- Physicians, nurse practitioners, psychologists, nurses, and social workers with the indicated WPATH competencies (see *Surgical Readiness Assessor Certification and Recommendation* form) may provide surgical readiness assessments. All health professionals providing a surgical readiness assessment for TRS patients must:
  i. complete the *Surgical Readiness Assessor Certification and Recommendation* form and submit it to the physician or nurse practitioner completing the TRS Request for Prior Approval.
  ii. provide a copy of the surgical readiness assessment to the physician or nurse practitioner completing the TRS Request for Prior Approval.

  Appendix A contains the recommended content for TRS surgical readiness assessments.

- The physician or nurse practitioner submitting the request for prior approval may also act as one of the surgical readiness assessors provided they: 1) have the minimum required credentials (see *Surgical Readiness Assessor Certification and Recommendation* form), 2) produce a surgical readiness assessment letter and 3) provide a signature on the *Surgical Readiness Assessor Certification and Recommendation* form.

- A list of health care professionals in the province with the minimum WPATH credentials for performing surgical readiness assessments is available at www.health.gov.nl.ca/health/mcp/pdf/TRS_SRA_NL.pdf.

- The Assistant Medical Director will notify the physician or nurse practitioner in writing of the outcome of the TRS Request for Prior Approval. The Assistant Medical Director will not notify the patient.

Newfoundland Labrador

Transition-Related Surgery
Request for Prior Approval

Patient Information Sheet
To be completed by the patient.

Name (as it appears on your MCP Card): _____

Name to be used for correspondence: _____
(If different from that which appears on your MCP card)

MCP Number: _____ MCP Expiry Date: _____

Address: _____

_____ Postal Code: _____

Phone Number: _____ Date of Birth (y/m/d):_____ Age:_____

Complete Patient Declaration

- A health care professional has explained the risks and complications associated with the proposed TRS procedure. **Yes / No**

- I understand that MCP covers the insured TRS procedures listed in Appendix B (List of Insured Transition-Related Surgeries) when they are provided within Canada at publically funded facilities. When insured TRS procedures are not available within Canada at publically funded facilities, prior approval may be granted for procedures performed at an approved private facility in Canada. **Yes / No**

- I understand there is no MCP funding for:
  - TRS services received without prior approval from MCP. **Yes / No**
  - TRS procedures not listed in Appendix B including facial feminization, liposuction, tracheal shave, voice pitch surgery and cosmetic surgical revisions. **Yes / No**
  - Any services which are not insured by MCP. **Yes / No**

****

Patient - Certification and consent

- I understand that I am personally responsible for the payment of any services which are not insured by MCP.
- I certify that the information given on this form is complete and accurate.
- I understand that my personal health information collected on this form and the attached supporting documents will only be used to process my request and will not be disclosed without my consent unless required by law.

Name (please print):_____

Signature: _____ Date: _____

Transition-Related Surgery
Request for Prior Approval

Clinical Eligibility for TRS
To be completed by a physician or nurse practitioner

1. Patient Name (as it appears on the MCP card): _____

MCP: _____

2. Physician or Nurse Practitioner Contact Information:

Name: _____

Provider ID # (if applicable) _____

Address: _____

Phone Number: (____) _____ Fax Number: (___) _____

4. Referring Physician or Nurse Practitioner Professional Declaration:

PRIMARY CLINICAL CRITERIA

I have verified that the patient has:

- Persistent, well-documented gender dysphoria. **Yes / No**
- Capacity to make a fully informed decision and to consent for treatment: **Yes / No**
  - Understands the procedure(s); **Yes / No**
  - Understands the associated risk(s) and complications. **Yes / No**
- Reasonably well-controlled medical or mental health concerns, if present. **Yes / No**
- Has an aftercare / follow-up plan **Yes / No**

SPECIFIC CLINICAL CRITERIA

Breast or Chest Surgery (mastectomy with chest masculinization, breast augmentation). Requires one surgical readiness assessment completed by a mental health professional who has also completed the attached Surgical Readiness Assessor Certification and Recommendation form.

- For breast augmentation, breast aplasia (no breast development) after 12 continuous months of hormone Therapy. **Yes / No / NA**

Genital Surgery: Hysterectomy, Salpingo-oophorectomy, Orchiectomy. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated). **Yes / No / NA**

Genital Reconstructive Surgery: Metoidioplasty, Phalloplasty, Vaginoplasty. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated) **and** 12 continuous months of living in a gender expression that is congruent with their gender identity. **Yes / No / NA**

Transition-Related Surgery
Request for Prior Approval

Patient MCP: _____

ADDITIONAL CLINICAL CRITERIA

- The patient is physically healthy. **Yes / No**
- There are physical health problems that may contraindicate or complicate the proposed surgery. **Yes / No**
- The patient is psychologically prepared for surgery. **Yes / No**
- The patient has realistic goals and expectations of the surgery. **Yes / No**
- The patient is informed of and understands any alternative procedures. **Yes / No**
- The patient has engaged in a responsible way with the assessment/treatment process. **Yes / No**
- The patient has an adequate support network. **Yes / No**
- The gender identity of the individual has remained stable over time. **Yes / No**
- The patient has regular visits with a health care provider. **Yes / No**

5. **Please use the space provided below to include any additional information which you may consider relevant to this Request for Prior Approval.** For example, you may wish to offer further details on the patient's experience of gender dysphoria or transition, on expectations for surgery, coping strategies, living situation or housing, etc.

6. Proposed procedure(s) for which prior approval is requested:

_____

(Please see list of insured TRS procedures, Appendix B)

7. Proposed facility and surgeon for which prior approval is requested:

_____

8. Referring Physician / Nurse Practitioner Declaration

- I have verified that the patient is a permanent resident of Newfoundland and Labrador and possesses a valid MCP card. **Yes / No**
- I have enclosed:
  - The Patient Information Sheet (completed and signed by the patient). **Yes / No**
  - One surgical readiness assessment and a signed Surgical Readiness Assessor Certification and Recommendation form (for patients recommended for breast or chest surgery). **Yes/No/NA**
  - Two surgical readiness assessments and two signed Surgical Readiness Assessor Certification and Recommendation forms (for patients recommended for genital surgery). **Yes / No/ NA**

9. Certification and Recommendation signature

- I certify that the information given on this form is complete and accurate.
- I recommend this client for Transition-Related Surgery.

Patient's Name (as it appears on the MCP card):_____

Patient's MCP_____

Name of Physician or Nurse Practitioner: _____

Physician/Nurse Practitioner Signature: _____ Date: _____

All information is collected under the authority of Part IV of the *Personal Health Information Act* for the purposes of approving transition-related surgery. For questions on how your information shall be collected, used and disclosed, please contact the Manager of Privacy and Information Security at 709-729-7010.

Surgical Readiness Assessor Certification and Recommendation

I certify that I meet the following minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioural science field. The degree, or a more advanced one, must be granted by an institution accredited by the appropriate national or regional accrediting board. The Mental Health Professional must have documented credentials from a relevant licensing board or equivalent.
2. Competency in using the *Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases* for diagnostic purposes.
3. The ability to recognize and diagnose/assess coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Documented, supervised training and competence in psychotherapy or counseling.
5. Knowledge about gender-nonconforming identities and expression, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that the mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

WPATH, Standard of Care, V.7

Patient Name (as it appears on the MCP card): _____

Patient's MCP number: _____

I recommend this client for Transition-Related Surgery.
I certify that the information given on this form is complete and accurate.

Name (please Print)

_____

Professional Designation :_____

Signature: _____ Date: _____

APPENDIX A:

WPATH Recommended Content of the Surgical Readiness Assessment

The WPATH recommended content of the surgical readiness assessment is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the Mental Health Professional is available for coordination of care and welcomes a phone call to establish this.

APPENDIX B:

The insured TRS services below are funded by the province's provincial health insurance plans when a TRS Request for Prior Approval document is completed and approved before the procedure takes place.

Breast or Chest Surgery:

- Breast augmentation when there is breast aplasia (no breast development) after 12 continuous months of hormone therapy.
- Mastectomy with chest masculinization (excluding implants and liposuction, which are not covered).

Genital Surgery:

- Hysterectomy
- Orchiectomy
- Salpingo-oophorectomy

Genital Reconstruction:

- Vaginoplasty (includes orchiectomy, penectomy, labiaplasty, clitoroplasty; with or without construction of the vaginal cavity)
- Metoidioplasty
- Phalloplasty (includes urethroplasty, scrotoplasty, vaginectomy, and insertion of testicular and approved penile implants)

Depending on the requirements of each individual patient, some of the above-listed procedures may be performed alone or in combination with each other.

Next Steps

This guide covers the basics of hormone therapy and the MCP surgery approval process. It's a starting point, and the national clinical guidelines included here are where you can build your knowledge. We hope you now feel ready to learn what you need to feel competent providing transition-related care to your patients.

You don't have to do everything at once. Every bit of learning makes it easier to say yes to the next patient, and too many people in this province are waiting for care that primary care providers are well placed to offer

Together we can make our healthcare system better for everyone in Newfoundland and Labrador

Continue the Conversation

If you're ready to build on what you've learned in this guide, we're here to help—whether that means improving your practice, educating your team, or strengthening policies and spaces.

Work Together

Trans Support NL offers support, advice, and consultation to members and leaders of organizations to help improve gender inclusivity. If you'd like to see change, visit us at **tsnl.org** or reach out to **info@tsnl.org**.

Give Feedback

Have an idea to improve this guide? Help us shape our approach to helping others learn.

Stay Updated

Sign up for our NL Gender-Affirming Healthcare Toolkit mailing list for new resources and updates.

Book a Workshop

Trans Support NL offers a variety of workshops to support organizations in understanding and addressing the needs of gender-diverse people.



Continuous Learning for Providers

Newfoundland & Labrador Resources

Family Practice Renewal Program

- Gender Affirmative Care (2 sessions)

MUN Faculty of Medicine, OPED

- Gender Affirming Care in Family Care Teams (Webinar)

Canadian-based Guidelines

Rainbow Health Ontario

- Sherbourne's Guidelines for Gender Affirming Primary Care with Trans and Non-Binary Patients (4th Edition)
- Gender Affirming Surgery Summary Sheets: Full Series
- Reproductive Options for Trans People
- Transition-related Surgery Post-surgical Care

Trans Care BC

- Gender-affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Care Toolkit

World Professional Assocation for Transgender Health

- Standards of Care for the Health of Transgender & Gender Diverse People, Version 8

Local Resources for Patients

Trans Support NL

Mending Mondays: Free counselling for gender-diverse people and their families. **tsnl.org/mending-mondays**

Peer Support: Monthly meetings in St. John's, Corner Brook, and Happy Valley-Goose Bay
tsnl.org/peer-support-group

Binder Swap: Free chest binders available province-wide
tsnl.org/gender-affirming-gear

Quadrangle NL

Quadrangle & Jacob Puddister Foundation: Free 2SLGBTQ+ counselling **thequadnl.com/counselling**

Trans Navigator: systems, documents, gender-affirming gear program, and resources navigation
thequadnl.com/trans-navigator

Planned Parenthood

Warm Line: Peer support for 2SLGBTQ+ community
plannedparenthoodnlshc.com/warmline

Trans Youth NL

Peer Support: Monthly meetings for parents and youth
transyouthnl.ca

YWCA

Programs and Services for LGBTQIA+ Newcomers
ywcastjohns.com/lgbtqia-services

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Looking to Learn More About Gender-Inclusive Healthcare Practices?

Small Changes, Big Impact: Improving Gender-inclusive Healthcare Practices in Newfoundland and Labrador is the first guide in our Toolkit. This offers an introduction to gender-diversity for anyone in healthcare!

Welcoming Spaces



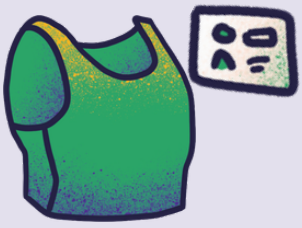
Introduction to Gender Diversity



Inclusive Documentation



Social and Legal Transition



Find this and other gender-affirming care resources at **tsnl.org**

TRANS
SUPPORT NL